

Care-as-Service, Care-as-Relating, Care-as-Comfort: Understanding Nursing Home Residents' Definitions of Quality

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Purpose: This study explored how nursing home residents define quality of care. **Design and Methods:** Data were collected through in-depth interviews and were analyzed using grounded dimensional analysis. **Results:** Residents defined quality in three ways: (a) Care-as-service residents focused on instrumental aspects of care. They assessed quality using the parameters of efficiency, competence, and value. (b) Care-as-relating residents emphasized the affective aspects of care, defining quality as care that demonstrated friendship and allowed them to show reciprocity with their caregivers. (c) Care-as-comfort residents defined quality as care that allowed them to maintain their physical comfort, a state that required minute and often repetitive adjustments in response to their bodily cues. **Implications:** Residents' perceptions of care quality have implications for long-term care practice. The integration of these perceptions into quality assurance instruments could improve the usefulness of tools designed to obtain resident input.

Key Words: Nursing homes, Long-term care facilities, Quality of care, Consumer quality assessment

The work of quality assurance (QA) has been described as encompassing three distinct tasks: defining quality, assessing quality, and assuring quality (Kane & Kane, 1988). Since the 1980s, health services researchers and policy makers have grown increasingly interested in incorporating the point of view of health care consumers into QA procedures (Davies & Ware, 1988). In the long-term care (LTC) arena, consumer perspectives have been used both to define the dimensions of quality (Grant, Reimer, & Banatyne, 1996; Grau, Chandler, & Saunders, 1995;

National Citizens' Coalition for Nursing Home Reform, 1985; Nores, 1997) and to prioritize the dimensions of quality that have been proposed by experts (Bliesmer & Earle, 1993; Mattiasson & Andersson, 1997; Pearson, Hocking, Mott, & Riggs, 1993). The trend toward involving consumers in LTC QA has been codified in legislation: The Omnibus Budget Reconciliation Act of 1987 includes the requirement that quality measurements incorporate assessments of resident satisfaction.

In some conceptualizations of quality in health care, consumers can play a central role in assessing and defining quality. The approach known as "patient-centered" care uses patients' assessments of their quality of life to indicate the presence of high-quality care (Aller & Coeling, 1995; Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993; Lutz & Bowers, 2000; Mattiasson & Andersson, 1997; Miller, 1997; Pearson et al., 1993). A second approach views autonomy—manifested in active participation—as key to quality (Ashworth, Longmate, & Morrison, 1992; Jirovec & Maxwell, 1993; Kane et al., 1997; Mitchell & Koch, 1997; Wetle, Levkoff, Cwikel, & Rosen, 1988). Here, individuals' perceptions of choice are used as one indicator of quality (Brocklehurst & Dickinson, 1996; Brooke & Short, 1996). A third approach conceptualizes quality care as care that meets the expectations of those who purchase it (Lengnick-Hall & Barton, 1995; Owens & Batchelor, 1996). Thus, quality is to be assessed through instruments that measure consumer satisfaction (Cleary & McNeil, 1988; Davis, Sebastian, & Tschetter, 1997; Jackson & Kroenke, 1997; Laitinen, 1994; Ludwig-Beymer et al., 1993; Pearson et al., 1993). A fourth approach uses ethnography to examine the experience—good or bad—of being a patient in the health care system or a resident in institutions devoted to restoring health or managing illness (Clark & Bowling, 1990; Goffman, 1961; Gubrium, 1975; Kane et al., 1997).

Although consumer perspectives are rarely the central determinant in overall assessments of quality, their use has provoked controversy. There is debate about how these views can best be gathered and used

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(Cleary & Edgman-Levitan, 1997; Lehr & Strosberg, 1991; Peters, 1993). Critics have argued that consumers cannot be competent judges of the technical elements of health care quality (Donabedian, 1980), seeing consumer quality assessments as more indicative of consumer characteristics and affective responses to interpersonal experiences than the actual quality of the service received (Grau et al., 1995; Larsson & Larsson, 1999). Defenders of the use of consumer quality assessment, however, citing studies that show good agreement between consumer assessments and a "gold standard" of expert assessment, assert that consumers *are* able to make competent judgments about the technical components of care (Davies & Ware, 1988). In addition, they argue that interpersonal experience constitutes an important dimension of quality, one that consumers are, in fact, uniquely qualified to assess (Carson, Carson, & Roe, 1998).

The characteristics of individuals who use LTC services have been seen as particularly problematic for including them in QA activities. Researchers have warned, for example, about threats to validity posed by factors like dementia, fatalistic resignation, low expectations, and fear of retaliation after unfavorable assessments (Aller & Coeling, 1995; Bliesmer & Earle, 1993; Grau et al., 1995; Laitinen, 1994; Pearson et al., 1993).

Despite these difficulties, several studies have sought to solicit the definitions of quality held by the residents of nursing homes. The most comprehensive—and the earliest—of these studies, a nationwide project conducted by the National Citizens' Coalition for Nursing Home Reform (1985), identified many of the dimensions of daily life in LTC facilities that were key to residents' ideas about quality of care. Overall, participants in this study defined quality care as having "choices and the ability to make them" (p. 15) in a happy, safe environment, being treated as individuals, and allowed to be independent. Later studies have emphasized the importance of social relationships in residents' perceptions of quality care (Grant et al., 1996; Grau et al., 1995; Mattiasson & Andersson, 1997).

The current research was designed to expand upon earlier work by looking at quality of care in an LTC facility from the point of view of the residents. As this report will show, residents' definitions of

quality centered on the intricacies of their relationships with their care providers, and on the consequences of care for physical comfort and sense of self.

Methods

This research was part of a larger study that examined care and caregiving practices in several LTC facilities from multiple perspectives. The portion of the study reported here focused on how nursing home residents conceptualize the quality of their care. The researchers used in-depth interviews and grounded dimensional analysis (Caron & Bowers, 2000; Glaser & Strauss, 1967; Schatzman, 1991; Strauss, 1987) to collect and analyze the data.

Data were collected at three LTC facilities in and around Madison, Wisconsin. The facilities served a range of income levels and had minimal deficiencies as indicated by state survey results. In order to facilitate comparison to the wider market, these facilities were purposely selected to reflect different owner types, payment sources, and resident income levels. (For more information about the facilities, see Table 1.)

Following approval by the human subjects committee, residents were recruited into the study by facility nurses who provided no direct patient care. (Institutional Review Board approval was contingent upon using a familiar staff person who was not a direct care provider to do the recruitment.) Researchers asked the nurses to invite participation from all residents who could understand what was being asked of them. The only residents nurses were instructed not to invite were those who were too ill or too cognitively impaired to participate in an interview. The nurses gave each resident a brief oral description of the research. Residents who were interested in participating completed a form indicating their name, room number, and a convenient time to contact them. The first nine residents in each facility to express an interest in participation were included in the research. (See Table 2 for more information about the residents.)

Early in the recruitment process, discussions between researchers and facility nurses revealed that the nurses were not recruiting residents they saw as "unrealistic" or "inappropriate" in their expectations. Further questioning revealed that these residents

Table 1. Characteristics of Long-Term Care Facilities

	Facility 1	Facility 2	Facility 3
Facility type	For-profit	Not-for-profit	Not-for-profit
Facility management	National chain	Church-sponsored/locally managed	Locally managed
Resident income level	Low to middle income	Middle and upper middle income	Upper income
Number of beds	103	184	64
Payment sources (by % residents)	70% Medicaid/9% Medicare/21% private pay	46% Medicaid/22% Medicare/32% private pay	100% private pay
Staffing levels	Above state-mandated minimums	Above state-mandated minimums	Above state-mandated minimums
Reputation in the community	Good	Good	Very good
State survey results	No level 3 deficiencies	No level 3 deficiencies	No level 3 deficiencies

tended to be the ones who were known to staff as “complainers” or as “difficult.” Sensing that the perspective of complainers might provide interesting data about quality, the researchers asked nurses to include residents with this reputation in the study, but not to reveal which residents were complainers until after all interviews were completed.

Interviews with residents took place in the residents’ rooms with only the resident and the interviewer present. Depending on the resident’s stamina, interviews lasted between 15 minutes and 2 hours. Most interviews lasted about 45 minutes. Residents were initially asked only to “talk about what it’s like to live here.” The purpose of this request was to have residents identify for the researcher those elements of their daily lives that they themselves found most relevant. Residents rarely needed further prompting or encouragement to talk.

Resident responses to these general questions often resulted in an initial evaluative response such as “It’s not so bad”; “It’s hell”; “It’s OK.” Residents were then prompted to elaborate on these responses. In particular, they were asked to give examples of experiences they had had in the nursing home, to describe what they found either “good” or “bad” about these experiences, and to specify how they had come to these conclusions. Analysis of their responses to these probing questions sought to delineate the dimensions of both “good” and “bad” care as conceptualized by the residents. As the study progressed, second interviews were guided by emerging analysis to further elucidate the dimensions of the participants’ experiences and perceptions of quality. All but one resident, who was discharged, were interviewed twice. The interval between interviews ranged from 7 to 10 days.

Interview data were analyzed using grounded dimensional analysis, an approach derived from grounded theory (Glaser & Strauss, 1967; Strauss 1987) and dimensional analysis (Caron & Bowers, 2000; Schatzman, 1991). Grounded dimensional analysis combines the key elements of grounded theory, including theoretical sampling and constant comparison, with the analytic framework provided by dimensional analysis. This framework explicates the phenomenon of interest (care quality) by prompting the analyst to conduct a rigorous examination of the perspective

from which the phenomenon is presented by the subjects, the context within which the phenomenon is described, the dimensions of the phenomenon, the conditions under which the phenomenon varies, and the consequences of the phenomenon.

In this study, analysis focused on how residents described the phenomenon of care, including identification of the dimensions of care or daily life that were used by residents when describing good or bad care. Comparative analyses across interviews suggested the three distinct types of resident quality definitions described in this article. Within each interview, there was a high level of consistency in the dimensions used to define quality. Further analysis of how these three types of definitions clustered by resident condition suggested that the definition of quality varied with level of functional impairment. Other variation in resident definitions of quality cannot be attributed easily to resident status. This variation and some of the implications are discussed below.

Results

Residents’ descriptions of quality fell into three categories. These categories tended to cluster by the resident’s level of dependency and by his or her reputation among nurses as “difficult.” (The significance of these resident characteristics for their definitions of quality was identified during analysis; the researchers did not use functional status and reputation as a complainer as *a priori* categories in the design or execution of the study.) Among the more independent group of participants, residents identified by staff as complainers tended to see care-as-service, whereas residents identified as ranging from “more reasonable” to “real sweeties” usually described care-as-relating. The very dependent group of residents, however, some of whom were also identified by staff as complainers or manipulators, defined care-as-comfort.

Care-as-Service

There were four participants who described care-as-service. Two resided in Facility 2 and two in Facility 3—the homes that served a middle and upper income clientele. These residents used the term “service” to refer to the staff work—passing food trays, making beds, assisting with bathing and personal care—that providers and researchers generally label care or caregiving. Residents who used the language of service focused on technical/instrumental aspects of care, including how well, how quickly, and how consistently the work was done. These residents perceived themselves as the purchasers of services and tended to compare their experiences in the LTC facilities with other instances in which they had paid people to provide them with specific services (e.g., appliance repair people or restaurant wait staff).

These residents suggested that they had the “rights” accruing to any consumer. For example, they believed that they should have the authority to instruct staff in how or when something should be done and that

Table 2. Characteristics of Participating Residents (N = 26)

Facility representation	9 from Facility 1 9 from Facility 2 8 from Facility 3
Age range	64–104
Sex	21 women 5 men
Lengths of stay	2 months–4 years
Functional status	14 independent (self-care; 7 or higher on SPMSQ [Pfeiffer, 1975]); 12 dependent (requiring help with bathing, toileting, walking, dressing, eating; 6 or higher on SPMSQ)

Note: SPMSQ = Short Portable Mental Status Questionnaire.

they were entitled to pass judgment on the adequacy of the services received:

When I'm paying so much I should have more to say. I'm paying good money to stay here, I should have better service. I pay \$3000 a month and I can't even get a glass of water when I want it.

Residents who conceptualized care as a purchased service made their own expectations important criteria for evaluating the quality of the care they were provided. As with other purchased services, their expectations for care had to do with value and work performed. These residents evaluated their care by how well the work was done, whether or not the outcome was of high quality, and whether the work was performed in a timely manner. They viewed themselves as active participants in evaluation, not simply the passive recipients of others' judgments of adequacy. They were often highly critical of the failure of their care providers to live up to their expectations, and frustrated by their inability to perform formal evaluations of the staff. As one resident stated, "It isn't right but they just do it the way they want. I have nothing to say about it." Another resident used even stronger language:

It's like robbery. . .you pay a fortune for a good place, thinking the service will be pretty good. Nobody has any pride in their work anymore. They just take your money and then you don't get the service you expect.

Residents who viewed care-as-service were likely to identify having to wait as particularly emblematic of poor quality service. When forced to wait, these residents made comments like: "I don't know why they don't train them better. . .[they] can't even figure out the simplest things"; and "[they] have no understanding of what sick people really need"; or "[they are] so unorganized, I mean, [they] use 100 steps to do something that would take someone with more common sense only 10."

Other residents perceived waiting as a demonstration of an implicit social hierarchy, and aides' wish to keep them at the bottom. These residents saw waiting as part of a power struggle, attributing specific motives to the care providers who made them wait: "It's not that they're so busy. . .you know. . .sometimes they're just standing around. . .they want to make sure we know our place. . .[and] know who's in charge"; or "They do it on purpose, you know. . .[making us wait] gives them a feeling of power."

Some residents who grew impatient with waiting described taking matters into their own hands, at times placing themselves in some physical jeopardy. In an effort to call attention to the unresponsiveness of some care providers, they were likely to make their actions, and the risks they had taken, widely known to the supervisory staff. According to these residents, this kind of "complaining" angered their care providers, but was effective in prompting at least a temporary increase in staff responsiveness.

Care-as-Relating

Sixteen participants—six in Facility 1, three in Facility 2, and seven in Facility 3—defined care-as-relating. When asked about care quality, these residents spoke about their relationships with staff. They emphasized the degree of closeness they experienced in these relationships, rarely mentioning actual caregiving activities or tasks. When pressed to speak specifically about the care they received, care-as-relating residents talked almost exclusively about the affect of their caregivers, their caregivers' motivation, and the evidence of real friendship that they found in their relationships.

Good care was described as care that was given by someone who "really likes her work. . .really cares about the people here." Care-as-relating residents spoke less about the technical aspects of care (the how and when described by care-as-service residents), but more about the signs of individualized affection and friendship they found in the care they received. Even under direct questioning about the technical aspects of care, these residents refused to acknowledge that it had any importance to them, insisting that factors such as competence were irrelevant. For example, residents were consistently willing to overlook care that might lead to poor outcomes if the caregiver's intent was consistent with a caring relationship. The woman quoted here, for example, excused an aide's failure to assist her with her daily exercises, including ambulation:

It's OK. . .you know. . .really. . . It doesn't matter so much. . .I'll get along. . . She's so sweet and tries so hard. . .and I wouldn't want to hurt her feelings.

Care-as-relating residents identified aides' willingness to share information about their personal lives, especially personal troubles, as an example of high-quality care. One resident described a favored aide: "She's really sweet, a good listener. She tells me about problems with her husband. . .and I give her advice." As suggested by this quotation, care-as-relating residents saw reciprocity as evidence of good relationships, and thus of good quality care. Residents often discussed reciprocity in terms of sharing invisible or past personal identities. An aide would share with the resident previously unknown personal details related to her life outside of work; in turn, the resident could share personal identities from his or her past. "Good" aides were described as attending to these identities as they provided care. By so doing, these aides were acknowledging resident selves other than those related to old age, illness, and disability. As one resident noted, a good aide was one who could "see me as not just an old lady or someone with bad knees and a catheter to clean."

By contrast, "bad" care was described as care that was given by someone who had "a bad attitude," who "obviously doesn't like her job," who "never smiles or looks me in the eye," who "doesn't keep promises," who "treats me like I'm invisible or stupid," or who "never just chats, you know. . .[is] just

all business.” Bad care was conceptualized by care-as-relating residents as care given by a provider who seemed to strive to minimize or eliminate the interactive dimensions of care and whose motivation was mercenary, rather than affective (i.e., aides who were “just in it for the money,” rather than out of a desire to help people).

Although residents who described care-as-relating were as likely as those who described care-as-service to experience waiting, the meaning they attributed to waiting and their response to waiting provide a sharp contrast to care-as-service residents. They did not see having to wait as demonstrating poor quality care. Rather, care-as-relating residents tended to excuse long waits in ways that suggested they were determined to absolve their caregivers of any responsibility for making them wait. Their comments about having to wait included: “[it’s] no one’s fault, really. . . just too much work to do” or “the girls work so hard, you know. . . [they’re] so overworked and short-staffed. . . they get there as quick as they can.”

Like care-as-service residents, care-as-relating residents sometimes described reacting to waiting by taking matters into their own hands. What they intended by doing so, however, was quite different. These residents saw taking action as an opportunity for them to demonstrate reciprocity. They described doing things for themselves in order to “save the girls time.” As one woman said, “They do so much and work so hard. I try to find little ways to take some of the burden off.” Some accounts suggested that these acts of reciprocity could endanger the resident. For example, a resident might mention to an aide that she had climbed over her bed rails so that she would not have to “bother” the aide with a request for her to lower them. Residents continued to take such risks, even when the intended recipient had objected: “She always scolds me but I know she really appreciates it. It’s our secret.” In keeping the action a “secret” between resident and caregiver, care-as-relating residents were demonstrating that they saw their actions as a means to strengthen interpersonal relationships, and not as ways to manipulate staff into providing better service.

Being able to reciprocate in this way was viewed as rewarding, particularly for residents who saw themselves as kind and helpful and unlikely to make “unreasonable” demands or to expect to be “waited on” by others. The following comment was typical: “I’ve always prided myself in helping out where I can. I’m the sort of person who doesn’t ask unless I really have to.” “Helping out” allowed residents to assert a treasured self: that of the uncomplaining, thoughtful friend.

Care-as-Comfort

Frailer, more dependent residents tended to describe quality as care that was directed at maintaining their physical comfort. Six participants—three each at Facilities 1 and 2 (the low and moderate income facilities)—defined care-as-comfort. Unlike the

less frail residents who focused on care-as-service and care-as-relating, these residents expressed tremendous concern about the specific hands-on care provided by aides. Although this group, like the care-as-relating residents, also mentioned the importance of having good relationships with staff, they viewed good relationships primarily as the means to ensure that they would receive timely assistance from aides.

The assistance that these residents found to be the most important was related to physical comfort, rather than to medical treatment, safety, or the routine mandated tasks that aides do for residents (i.e., bed making, bathing, cleaning the rooms). Residents’ accounts of good quality care were frequently focused on having something “just right.” Maintaining a sense of “just right” required attending to very small, often invisible, increments of bodily changes that were generally not appreciated by staff. For example, these residents described how propping up an aching leg in just the right position could make a huge difference between comfort and “terrible” discomfort. Similarly, the difference between a refreshing drink of water and one that was offensive was, literally, a matter of degree. The discrepancy between the apparent magnitude of these differences as perceived by staff and the significance for the residents was huge.

Residents who sensed the staff’s resentment grew frustrated and angry, both with the staff and with themselves:

I tell them I have to go to the bathroom and I can’t wait and they still don’t come. It’s cruel to make someone wait when they know it’ll mean an accident. Sometimes I can’t go and they get so disgusted, and even if they don’t, I feel bad. I’m taking up their time.

As suggested by this quotation, loss of the ability to read body cues (a loss related to age and, often, the side effects of numerous medications and treatments) exacerbated the repetitive and sometimes unproductive nature of the tasks that residents required for their personal comfort. Staff did come to resent repeated requests to do these tasks, and often began to contest residents’ attempts to read their own body cues: “No, you don’t have to go to the bathroom, we just took you and you didn’t have to go, remember?” or “You couldn’t possibly be cold, it’s 82 degrees in here.”

The uncertainty attached to reading body cues created a dilemma for residents: to ask for assistance or not to ask? The consequences of making the wrong decision, in either direction, were significant. Residents who suspected that they had to urinate, but weren’t sure, for example, ran the risk either of wetting the bed, an event that created further discomfort, humiliation, resentment, and, eventually, more work for the staff, or of antagonizing their caregivers by asking for help with what might turn out to be an “unnecessary” trip to the toilet. Because they wished to minimize unnecessary work and didn’t want to gain reputations for “crying wolf,” residents often

selected "waiting until I can't stand it" as the most reasonable, albeit agonizing, option.

Discussion

The three conceptualizations of quality described by the nursing home residents who participated in this study show some areas of overlap with those specified in the definitions of quality proffered by experts. The care-as-service residents, for example, fit well into the consumerist model of those who seek to assess quality by measuring consumer satisfaction. The wide range in resident-derived definitions of quality, however, points out the inadequacy of relying upon one conceptualization of quality for QA procedures. For example, consumer satisfaction surveys that focus on the technical aspects of care might be rejected by care-as-relating residents because these residents view themselves as friends, not consumers, and would see criticizing their caregivers as disloyal. Instruments to measure choice would be perceived as ironic, at the least, and even as cruel by the care-as-comfort residents for whom "autonomy" means choosing to suffer rather than antagonize their caregivers. Care-as-service residents would likely reject the idea that facilities have any right to determine the dimensions that compose their "quality of life," but would see such attempts as presumptuous, not the place of those whose purpose is to serve. However, this group may well be the most credible source of consumer satisfaction assessment because they are willing to provide negative judgments.

The significance of these findings lies primarily in their implications for the measurement of care quality and for how knowledge about quality can be applied to practice. First, the current emphasis on expert-defined clinical aspects of care, such as those encompassed by the Minimum Data Set quality indicators (MDS/QI), does not acknowledge the complexity of quality as it is experienced by nursing home residents. From the point of view of most residents, focusing regulation and practice efforts solely on improving or maintaining these clinical dimensions may not result in adequate quality of care as they themselves define it. The findings reported here provide support for the current Health Care Financing Administration-funded efforts to develop an MDS specifically directed at resident quality of life. For example, care-as-relating would fit more easily into quality of life than it does into the domains that measure quality of care. Care-as-service and care-as-comfort, however, cannot be neatly placed into either category. In particular, comfort, as described by the residents who participated in this research, is not captured by either quality of care or quality of life. The closest category currently found in the MDS is pain. This category is, however, practically and conceptually different from what residents described. Addition of a new "comfort domain" might improve the ability of the MDS to assess quality in a way that is meaningful to residents.

These findings also have important implications for two areas of practice: determining the staffing

needs required to deliver quality care and improving clinical practice. Currently there are no federally mandated staffing rules for nursing homes except the requirement that staffing be adequate to ensure high-quality care. The staffing levels necessary to provide such care, however, are highly contested (Bowers, Esmond, & Jacobson, 2000). Most attempts to determine "adequate" staffing levels base their assessments on associations between staffing and results on the MDS/QI. As this study has suggested, these expert-defined clinical dimensions may not capture what constitutes quality for nursing home residents. As applied to clinical practice, these findings have significant implications for resident needs assessment, care planning, in-service education, and staff supervision. An understanding of the resident definitions described in this article would improve practitioners' ability to plan and deliver individualized care and to evaluate the quality of care provided in ways that are meaningful to residents.

The limitations of the work reported here are largely inherent to the exploratory nature of the study and to the interpretive methodology used. The small sample size allowed greater analytic richness but was inadequate to ensure external validity. The study was cross-sectional. Researchers were unable to ascertain if residents' conceptualizations of quality shift over time. For example, as suggested by one of the anonymous reviewers of this article, it may be that residents become increasingly "institutionalized" as their stays lengthen, adopting definitions of quality that are more congruent with those of their care providers. The design of this study also did not allow linkages between resident conceptualizations of quality and resident characteristics such as socioeconomic (SES) or functional status.

In the future, it will be important to determine the generalizability of the three types of care quality definitions described in this article. Further research might test the associations between functional status (and characteristics like SES, race, and gender) and resident definitions of care quality. It might also develop a "natural history" of resident conceptualizations of quality through longitudinal study, and look at the relationship between resident perceptions of quality and contextual factors such as facility staffing levels and the nature of resident/staff relationships.

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